

After you have received medical care, you may be wondering how much that service actually cost and if you will owe more than any co-payment you may have already made.





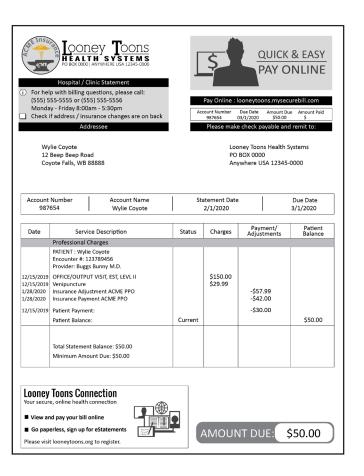
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Your Benefits Explained

A Walk-Through of an Explanation of Benefits (EOB)

A healthcare provider will bill your health insurance company after you've received your prescribed care. Then you'll get an Explanation of Benefits (EOB), which is a summary of the cost of any healthcare services you received. If you owe anything, you will get a separate bill from your provider. This bill will include instructions on how to pay the bill and to whom you should pay it, whether that's a healthcare provider or your health insurance company.

Sample Bill



PATIENT ADVOCATE FOUNDATION Health Insurance Education Series Helping you chart your course

Service Description	Billed	Allowed	Plan	Your	Co-Pav	Deductible	Coinsurance	Not		Remar Code
Venipuncture (36415)	\$29.99	\$22.00	\$22.00	\$7.99	\$0.00	\$0.00	\$0.00	\$0.00		
Office Visit (99213)	\$150.00	\$100.00	\$20.00	\$50.00	\$30.00	\$50.00	\$0.00	\$0.00	\$80.00	01, 41
	\$179.99	\$122.00	\$42.00	\$57.99	\$30.00	\$50.00	\$0.00	\$0.00	\$80.00	-
In-Network Benefit				Applied Amount			Remaining Annual Limit			nit
Individual Deductible			\$1,500.00				\$0.00		\$1,500.00	
In Tual In-Network Out-of-Pocket Maximum			£	1,530.00			\$1470.00 \$3,000.00		D	
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Sample Explanation of Benefits

The EOB includes how much you were charged for any medical care you received, how much your health insurance company paid for that care and how much you are responsible to pay. It is always a good idea to keep any bill you receive from the provider and compare it to the EOB before paying.

- 1 Details about when and what care was provided can be found under the **Date and Type** of service columns. This could refresh your memory especially if you had different services performed on multiple days such as a routine doctor's visit, lab testing prior to undergoing a surgical procedure or it may have been for routine preventative screening.
- 2 **Billed Amount** or amount charged is the price for each medical service or treatment provided. This is the price you would have been charged if you didn't have health insurance.
- **3** Allowed Amount is set by the insurance plan after they subtract any charges that are not covered and apply the provider discount from the billed amount. This amount can vary based on the average price for a specific procedure code where you live.
- 4 **Provider Payment** is the dollar amount your insurance plan paid your provider. In most cases the payment has already been made before you receive your EOB.
- **5 Co-Pay Amount** is how much you are required to pay a provider each time you receive a certain type of service. This is a fixed amount determined by the health plan. An example would be having to pay \$30 each time you see your primary care doctor.
- 6 **Deductible** shows how much of a claim if any was applied to your annual deductible. You are responsible to meet the individual deductible amount before insurance begins to

pay their share of the medical bill. There is an exception to this: Annual preventative exams are required to be covered by the insurance plan at no cost to you. The deductible amount is determined by the health plan and can change each year.

- Co-Insurance Amount is your share of the cost of a healthcare service. This is calculated as a percentage of the allowed amount. An example would be if insurance pays 70% of the allowed amount, you pay the remaining 30%. This is your co-insurance. You start paying co-insurance after you meet your annual deductible, and it counts against the out-of-pocket maximum.
- 8 Total You Owe is the amount the insurance plan determined that the patient owes the medical provider. This amount may be the same as your co-payment that you paid at the time you received the service. If the amount is more than your co-payment, you should expect to receive a bill from the provider.
- **9 Out-of-Pocket Maximum** is a set amount of money that you will have to pay in a calendar year for covered medical costs. In most plans there is no cost sharing for covered medical services after you have met your out-of-pocket maximum.
- 10 The last area of your EOB is the **Explanation or Remark Codes**. This is a note from the insurance plan that explains any specifics about how the charges were covered, if any discounts were applied and finally, the amount that was paid or not covered for your healthcare.







